

# KANSAS MEDICAID STATE PLAN

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## Method and Standards for Establishing Payment Rates: Nursing Facilities

### Rates When Two Or More Nursing Facilities Merge Under One License

#### Scenario One: Provider files 12-Month Cost Report Ending on December 31 for a January 1 Rate:

Two facilities combine under one license on June 1, 1998. Facility A has been filing calendar year cost reports for rates. Facility B was recognized as a change of provider on January 1, 1998.

#### Initial Rates:

Facility A will be paid a separate rate for June 1998 services based on the calendar year 1996 cost report. It will be paid a separate rate for services beginning July 1998 through June 1999, based on the calendar year 1997 cost report.

Facility B received the previous provider's rate for January through December 1998, based on the calendar year 1996 cost report filed by the previous provider. Facility B will continue to receive rates based on the calendar year 1996 cost report until the first cost report is filed for the period from January 1, 1998 through December 31, 1998.

#### Subsequent Rates :

The provider will file a cost report for Facility B for the 12-month period ended December 31, 1998. The cost report would reflect only that facility's first year of operation and would be used to set a rate for January 1, 1999.

The provider will file another combined 12-month cost report for Facilities A and B for calendar year 1998. This calendar year cost report will be used to set one rate for the facilities under one license on July 1, 1999. At that time, all but one of the provider numbers will be deactivated and the remaining provider number will be used for the multiple facilities.

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#### Scenario Two: Provider files 11-Month Cost Report Ending on December 31 for a January 1 Rate:

Two facilities combine under one license on June 1, 1998. Facility A has been filing calendar year cost reports for rates. Facility B was recognized as a change of provider on February 1, 1998.

#### Initial Rates:

Facility A will be paid a separate rate for June 1998 services based on the calendar year 1996 cost report. It will be paid a separate rate for services beginning July 1998 through June 1999, based on the calendar year 1997 cost report.

Facility B received the previous provider's rate for February through December 1998, based on the calendar year 1996 cost report filed by the previous provider. Facility B will continue to receive rates based on the calendar year 1996 cost report until the first cost report is filed for the 11-month period from February 1, 1998 through December 31, 1998.

#### Subsequent Rates:

Since the change of provider in Facility B is effective February 1, 1998, the first cost report will be filed for the 11-month period from February 1, 1998 to December 31, 1998. The cost report would reflect only that facility's operation for the 11-month period and would be filed to set a rate for January 1, 1999.

A second combined cost report would be filed for both Facilities A and B for calendar year 1998. It would reflect 12 months of operation for Facility A and 11 months of operation for Facility B. The combined cost report would be used to set a rate for July 1, 1999. At that time, all but one of the provider numbers will be deactivated and the remaining provider number will be used for the multiple facilities.

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#### Scenario Three: Provider files 13-Month Cost Report Ending on December 31 for a January 1 Rate:

Two facilities combine under one license on June 1, 1998. Facility A has been filing calendar year cost reports for rates. Facility B was recognized as a change of provider on December 1, 1997.

#### Initial Rates:

Facility A will be paid a separate rate for June 1998 services based on the calendar year 1996 cost report. It will be paid a separate rate for services beginning July 1998 through June 1999, based on the calendar year 1997 cost report.

Facility B received the previous provider's rate from December 1997 through December 1998, based on the calendar year 1996 cost report filed by the previous provider. Facility B will continue to receive rates based on the calendar year 1996 cost report until the first cost report is filed for the 13-month period from December 1, 1997 through December 31, 1998.

#### Subsequent Rates:

Since the change of provider in Facility B is effective December 1, 1997, the first cost report will be filed for the 13-month period from December 1, 1997 to December 31, 1998. The cost report would reflect only that facility's operation for the 13-month period and would be filed to set a rate for January 1, 1999.

A second combined cost report would be filed for both Facilities A and B for calendar year 1998. It would reflect 12 months of operation for both Facilities A and B (not a 13-month period for Facility B). The combined cost report would be used to set a rate for July 1, 1999. At that time, all but one of the provider numbers will be deactivated and the remaining provider number will be used for the multiple facilities.

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#### **Combined Calendar Year Cost Report For Nursing Facilities Merged Under One License**

The cost reports will be for the full 12-month calendar year except if the 11-month cost report period applies. The number of beds, resident days, Medicaid days and Medicare days will be the total for the facilities merged under one license. All changes in the number of beds during the calendar year will need to be reflected for the merged facilities.

The working trail balances for the merged facilities will need to be combined to fill out the schedules in the cost report. Schedule A, Expense Statement shall reflect the total staff hours and the total direct and in-direct expenditures for the merged facilities. The total revenue and related revenue offsets in Schedule G, Revenue Statement, shall be the total for the merged facilities. For part of the calendar year, the working trail balance may reflect the independent operations for each facility and then following the merger the working trail balance may be consolidated. The working trail balances shall reconcile to the applicable cost report schedules. A schedule that lists all general ledger accounts grouped by cost report line number shall be submitted with the combined cost report.

#### **Resident Days Used in Denominator:**

The greater of the actual resident days reported for the merged facilities or days calculated at the 85% minimum occupancy will be used in the denominator of the rate calculation. If the 85% occupancy rule does not apply during the first 12 months of operation of a facility, then actual days will be used for that facility for the period that the rule does not apply. A merged facility is not treated as being in the first 12 months of operation if the provider had operated the independent facilities previously. If only one of the facilities did not have the 85% occupancy rule applied then the provider will need to report the number of beds and resident days separate for that facility so that the available bed days for the merged facilities can be determined.

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#### **Real and Personal Property Fee (Property Fee) For Merged Facilities:**

The data elements in the most current property fee for each facility will be merged to determine the combined property fee for the facilities merged under one license. The resident days reflected in the Real and Personal Property Fee Component summary for each facility will be totaled. For example, if Facility A has 10,000 resident days reflected and Facility B has 15,000 days, the total days will be 25,000.

Each of the four expense components (interest, depreciation, rent/lease and amortization of leasehold improvements) will be summed for the facilities merged. The total of the four expense components will then represent the total property fee expenses for the merged facilities.

The property allowance will be based on the weighted-average of the merged facilities. For example, Facility A has a property allowance of \$4.00 per day and the current Real and Personal Property Fee Component line reflects 10,000 resident days and Facility B has a property allowance of \$5.00 per day and 15,000 resident days. The weighted-average property allowance will be \$4.60 ( $\$4 \times 10,000 \text{ days} + \$5 \times 15,000 = \$115,000 / 25,000 \text{ total days} = \$4.60$ ).

The value factor will be based on the Medicare per diem property allowance ranges if all or part of the merged facilities is certified to participate in the Medicare skilled nursing facility program. If none of the merged facilities are Medicare certified, then the Nursing Facility per diem ranges are used. In the example above, if one of the facilities was Medicare certified, the value factor would be \$.34 for a total property fee of \$4.94. If both facilities were not Medicare certified, the property value factor would be zero and the total property fee would be \$4.60.

#### **Resident Assessments and Case Mix Index**

The resident assessment database, based on the minimum data set (MDS), for the facilities merged under one license will be combined beginning with the first quarter after the merger. The facilities will continue to receive separate rates until after the common calendar year cost report is received for a July 1 rate. However, the case mix index will

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be the same for the facilities when determining rates after the MDS data base for each facility are merged in the first quarter after the facilities are under a combined license.

### Rates for Facilities Under One License If They Later Decide to Go Back To Separate Licenses

#### Cost Reports and Rates

If two or more facilities merge under one license and later decide to go back to individual licenses, they will keep the merged rate until a calendar year cost report can be filed for a July 1, rate. For example, if two facilities that were merged under one license decide to have separate licenses on September 1, 1999, the two facilities will be required to submit separate calendar year 1999 cost reports for each facility. The provider shall document how costs and revenues are allocated to each of the facilities during the period the financial statements were combined.

When the two facilities are under separate licenses, the provider number that was deactivated when the facilities merged will be re-activated. Initially, both facilities will have the same rate. The calendar year 1999 cost report will be used to determine rates for each facility on July 1, 2000.

#### Real and Personal Property Fees

If two or more facilities that are merged under one license later decide to split and have individual licenses within five (5) years, the old property fees will be reassigned to the individual facilities. The additional allowance for a property fee rebasing after the property fees were combined would be added to the individual property allowances after the facilities split. The two facilities used in the combining of property fees above had a property fee of \$4.60. As an example, if a property fee rebasing took place later that added \$.50, the property fee will be \$5.10. If Facilities A and B split before five years, the property fee for Facility A will be \$4.50 (\$4.00 + \$.50) and the property fee for Facility B will be \$5.50 (\$5.00 + \$.50).

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If the facilities decide to split and go back to individual licenses after five years, each facility will continue to have the same property fee as determined when they merged.

### Resident Assessments and Case Mix Index

If the two facilities later decide to split into separate licenses, the MDS database will be maintained for the individual facilities beginning the first quarter after the facilities have separate licenses.

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## Methods and Standards for Establishing Payment Rates: Skilled Nursing and Intermediate Care Facility Rates (Currently Nursing Facilities)

### Reimbursement For Nursing Facilities With Over 199 Beds

Nursing facilities (NFs) with over 199 beds, who are reimbursed on the basis of a projected of historical cost report, shall be limited by an overall total rate approved by the Secretary of the agency. The rate shall be reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities. Special level of care groups are only established when the characteristics of the facilities or residents are so unique that reimbursement under the usual methods and standards for establishing payment rates for NFs are not reasonable or adequate.

The following parameters shall be used in setting rates for NFs with over 199 beds:

1. They are required to submit the uniform Nursing Facility Financial and Statistical Report in accordance with Exhibit A-5. The treatment of allowable costs are consistent for all NFs, regardless of size.
2. The per diem rates are determined by applying the 85 percent minimum occupancy rule, administrator/co-administrator/owner/related party compensation limits, inflation factors and the incentive factors, as applied to all NFs, regardless of size.
3. The rates are held to the upper payment limits for the Administration, Property, and Room and Board cost centers. They are not held to the upper payment limit for the Health Care cost center.
4. The property reimbursement (real estate interest, depreciation, lease and amortization of leasehold improvements) is based on the real and personal property fee. The overall property limit established for NFs with less than 200 beds is applied to these facilities. The payment methodology is not reasonably expected to result in a increase in payments based solely on a change of ownership in excess of what would be allowed for any other NF.

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### Reimbursement For Nursing Facilities With Over 199 Beds

5. The payment rate can not exceed the private pay rate for comparable services. The related requirements in Exhibit A-6 shall be followed.
6. The rates are not expected to pay more in the aggregate for NF services than the amount that the agency estimates would be paid under the Medicare principles of reimbursement.
7. Rates for the facilities are determined at least annually based on submissions of the uniform cost report.

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### Nursing Facility Quality Enhancement Wage Pass-Through Program

The Kansas Legislature, during the 1999 session, adopted Senate Bill (SB) 126 (1999 Kan. Sess. L. ch. 101), an Act to establish the quality enhancement wage pass-through program for nursing facilities. Nursing facilities electing to participate in this program can increase salaries or benefits or both for those employees providing direct care and support services to nursing facility residents. This Bill includes the following proviso: "All expenditures for the quality enhancement wage pass-through program shall be made only from moneys specifically appropriated therefor." The Governor signed the Bill into law on April 14, 1999.

House Bill (HB) 2489 (1999 Kan. Sess. L. ch. 160, §§ 2-3) included the appropriations for SB 126 for State fiscal year 2000 (July 1, 1999 through June 30, 2000). The Kansas Department of Social and Rehabilitation Services (SRS) was appropriated state general funds of \$224,402 to fund the nursing facilities-mental health (NF-MH) and intermediate care facilities-mentally retarded (ICF-MR). The Kansas Department on Aging (KDOA) was appropriated state general funds of \$1,725,000 to fund the nursing facilities, including hospital-based long-term care units (NF).

Under SB 126 the Secretaries of SRS and KDOA are required to establish a Medicaid State Plan provision for the quality enhancement wage pass-through program. The pass-through may not exceed \$4.00 per resident day. Participation in the program is voluntary but limited to the available funds. Copies of SB 126 and the relevant parts of HB 2489 are included in the Medicaid State Plan exhibit.

### Criteria for Prioritizing Applications:

The providers must submit a completed application to KDOA for NF and NF-MH on a form prescribed by the Secretary of each agency. The applications will be placed in a primary group if they are received by the due date below. The secondary group of applications are those received after the first due date and will be time and date-stamped based on receipt. Following is the procedure for treatment of the two groups of applications.

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